TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Hospital for Specialized Surgery

MFDR Tracking Number
M4-14-0642-01

MFDR Date Received
October 28, 2013

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the attached Surgery Scheduling Forms (attached) Dr. Mark Henry deemed the patient's condition a **MEDICAL EMERGENCY** and with a time sensitivity of **WITHOUT DELAY**. Therefore no authorization is required for the services…"

Amount in Dispute: $6,394.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation here simply does not establish a medical emergency as defined by Rule 133.2. Thus, preauthorization was required. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2013	11043	$6,394.18	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1 – Workers compensation state fee schedule.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-197 – Precertification/Authorization/Notification absent
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
   - 724 – No additional payment after a reconsideration of services.
   - 786 – Denied for lack of preauthorization.
   - CAC-18 – Duplicate claim/service.
   - 224 – Duplicate charge.

Issues

1. Did the requestor support the definition of an emergency?
2. Was preauthorization required?

Findings

1. 28 Texas Labor Code §133.2(5) states in pertinent part, "(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   Review of the submitted medical record finds a History and Physical Exam Report dated July 12, 2013 that states in part, "The patient has requested that a surgical procedure be performed. This was selected by the patient from among other options including the option of non-surgical management of the problem. The patient has voiced understanding that surgery comes associated with numerous potential risks that have been reviewed today..."

   The Division finds that the documentation submitted by the requestor does not met the definition of "emergency" as defined by 28 Texas Administrative Code 133.2 (5).

2. 28 Texas Administrative Code §134.600 (p)"Non-emergency health care requiring preauthorization includes (2) outpatient surgical or ambulatory surgical services."

   The Division finds that preauthorization was required for the disputed service and not obtained by the requestor. As a result, reimbursement for the disputed service rendered on July 12, 2013 is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 22, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.